MANATT HEALTH SOLUTIONS

OVERVIEW OF PROPOSED EXCHANGE, MEDICAID AND IRS REGULATIONS

WORKING DRAFT

Prepared by Manatt Health Solutions

for the California HealthCare Foundation

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I. INTRODUCTION

On August 12, 2011, federal officials issued three draft regulations that, taken together, offer new insight into how consumers and small businesses will obtain health insurance across the continuum of coverage contemplated in the Patient Protection and Affordable Care Act (ACA). The U.S. Department of Health and Human Services (HHS) released two proposed regulations. One addresses Medicaid and CHIP eligibility, enrollment simplification, and coordination[1]; the other focuses on eligibility determinations for participation in "Affordable Insurance Exchanges" (Exchanges), insurance affordability programs, Qualified Health Plans (QHP), and standards for employer participation in Small Business Health Options (SHOP) exchanges[2]. A third proposed rule was released by the Internal Revenue Service (IRS) of the Treasury Department: the Health Insurance Premium Tax Credit rule[3] addresses eligibility requirements for premium tax credits and provides guidance with respect to calculating the premium assistance amounts and reconciling advance payments with actual credits at year-end.

Released on the heels of the latest round of Exchange Establishment Grant awards (in which California was awarded nearly $40 million), the three proposed rules provide a new level of operational detail that informs California's planning efforts, guides the design and implementation of business processes, IT and administrative systems, and, ultimately, will impact consumer experience with the California Health Benefit Exchange and Medi-Cal. Many provisions will require changes in State policy and practice; some may require changes to State law.

With largely overlapping but sometimes divergent definitions and operational requirements, the rules are best understood in concert, and with proposed rules issued by HHS on July 11, 2011, *Establishment of Exchanges and Qualified Health Plans (CMS-9989-P)*.

The purpose of this analysis is to provide an overview of the main provisions of the proposed rules and their implications for State implementation. This section describes key takeaways from the proposed regulations. Section II provides an overview and analysis of the Exchange and Medicaid regulations and Section III discusses the IRS regulations.

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[1] *CMS-2349-P*, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 76 FR 51148, hereinafter Medicaid regulations.
[2] *CMS-9974-P*, "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers," 76 FR 51202, hereinafter Exchange regulations.
[3] *REG-131491-10*, "Health Insurance Premium Tax Credit," 76 FR 50931, hereinafter IRS regulations

THEMES, IMPLICATIONS AND KEY FINDINGS

The regulations balance several sometimes competing goals related to the processes for consumers to obtain health insurance: minimizing administrative burden for system users and operators (Exchanges and States), maintaining accuracy and program integrity, and maximizing seamlessness across the continuum of coverage. They outline eligibility criteria and enrollment processes for unsubsidized enrollment in a QHP, as well as for "Insurance Affordability Programs," the continuum of subsidized coverage options embedded in the ACA – Medicaid, CHIP, advance payments of premium tax credits and cost-sharing reductions through the Exchange, and any State-established Basic Health Program (BHP).

With a focus on coordinated eligibility and enrollment processes between the Exchange and Medi-Cal, reliance on electronic data verification to the maximum extent possible, and determinations of eligibility performed in real-time, the proposed rules reinforce the urgency of the planning already underway in California. Under California's Health Benefit Exchange planning process, an initial IT gap analysis primarily focused on eligibility and enrollment functions highlighted several limitations in California's current assets. Existing public program eligibility determination and case

Key Takeaways for California

- *Provides **operational detail** to implement ACA eligibility and enrollment requirements while preserving **state flexibility** to create equal or better alternatives.*
- *Mandates integrated and simplified eligibility processes for **"Insurance Affordability Programs"** - the continuum of subsidized coverage including Medicaid, CHIP, Basic Health Program and tax subsidies.*
- *Requires **interagency coordination** between the California Health Benefit Exchange, the Department of Health Care Services, the Managed Risk Medical Insurance Board, consistent with California's Health Benefit Exchange authorizing statute.*
- *Outlines a series of mandatory and optional **formalized agreements defining agency responsibilities**.*
- *Relies on **electronic data matching** as the primary means for verifying eligibility, requiring other forms of verification only when the match is not "reasonably compatible."*
- *Depends on **new and robust IT systems and interfaces**, including a federal hub and modernized California eligibility systems.*
- *Eliminates specific timeliness requirements under Medicaid in favor of **real time eligibility determinations**.*
- ***Aligns household income definitions** while carving out exceptions to preserve existing coverage under Medicaid.*
- *Requires step-children, step-siblings and **step-parents to be counted** as part of the household in determining Medi-Cal eligibility which could result in a loss of coverage for some California families.*
- *Give states **FMAP modeling options** for determining which populations are "newly eligible" without requiring case by case screenings.*

managements systems and public websites with application submission and client service functionality do not include the full scope of required functionality. And, existing functionality was not developed to meet the objective of real-time eligibility determination contemplated in the proposed rules. These systems are also administered by various State and local agencies and their contractors resulting in potentially further complexity in the planning and implementation. Implementation of the proposed rules will require most States to design and build new eligibility and enrollment systems, modernize and transform existing ones, and ensure appropriate interfaces are established for data exchange.

Alignment of Eligibility Criteria for Insurance Affordability Programs

The proposed rules stress the value of aligning methods for determining eligibility across all Insurance Affordability Programs:

> "The alignment of the methods for determining eligibility is one part of an overall system established by the Affordable Care Act that allows for real-time eligibility determinations of most applicants and allows for prompt enrollment of individuals in the insurance affordability program for which they qualify. Individuals will not have to apply to multiple programs nor will they be sent from one program to another if they initially apply to a program for which they are not ultimately eligible. To achieve coordination, this proposed rule for Medicaid and CHIP eligibility is aligned with the applicable provisions in the proposed rule establishing the Exchanges." (Medicaid Preamble I(A))

For the most part, the rules successfully align the processes by which individuals will obtain health insurance coverage, and the underlying criteria that will be the basis for eligibility determinations across the continuum of health insurance subsidies, as mandated under the ACA. However, the proposed rules also call out several specific areas where policies across coverage programs diverge. In general, where policies diverge it is either to avoid disruptions in coverage for those currently eligible for Medicaid, or because federal statutory requirements prevent alignment. Examples of differing eligibility requirements include the following:

- All Insurance Affordability Programs rely on MAGI-based income standards (MAGI is defined in section 1.36B-1(d)(2) of the IRS regulations); however, Medicaid determines eligibility based on current income while income eligibility for advanced premium tax credits is based on projected annual income.

- For the purposes of determining eligibility for tax credits, the IRS proposed regulations define a family as those individuals for whom a taxpayer properly claims a personal exemption for a taxable year. The

definition of a household under the Medicaid proposed rules starts with this tax filing unit, but provides for some Medicaid-specific exceptions. For example, the Medicaid proposed rule allows children living with caretaker relatives, such as grandparents, to apply for Medicaid without consideration of the relatives' income. The commentary notes that alignment of this Medicaid rule with the IRS definition of family would risk disrupting coverage for children and increasing financial obligations for grandparents and other caretaker relatives.

- The rules identify three types of income that Medicaid will treat differently than they will be treated for evaluation of eligibility for advance tax credits. These are: lump sum payments; scholarships and grants; and income of American Indians and Alaska Natives.

- "Federal Poverty Level" (FPL) for determination of eligibility for advance payment of premium tax credits is the most recently published FPL as of the first day of the annual open enrollment period; in Medicaid, FPL is the published percentage as of the date of application. An individual who seeks to enroll in Insurance Affordability Programs during certain points in the year could be subject to one FPL amount for Medicaid and a different amount for advanced payment of premium tax credits.

Ultimately all applicants for Insurance Affordability Programs will be evaluated under the Medicaid rules first, since an individual cannot be found eligible for CHIP, BHP or advance payment of tax credits without a finding that he/she is ineligible for Medicaid.

Interdependency of and Agreements Between Exchange and Medicaid/CHIP Agencies

The proposed rules make clear the interdependency of State Exchanges and Medicaid agencies in determining eligibility for QHP and Insurance Affordability Programs. To ensure the requisite coordination, the regulations contemplate multiple areas in which the Exchange and Medicaid/CHIP agencies must or may enter into agreements to carry out new responsibilities including with respect to:

- Compulsory coordination of eligibility processes for Insurance Affordability Programs, including coordination with a BHP, if applicable;

- Compulsory data sharing including confidentiality and security arrangements. In addition to entering into Agreements with Exchanges, Medicaid Agencies must also enter into data sharing agreements with other State agencies from which data will be requested;

- Optional delegation to the Exchange of Medicaid/CHIP health plan or delivery system (such as primary care case management) selection and transmission of enrollment transactions to health plans;

- Optional delegation to Medicaid of the Exchange's responsibility to determine eligibility for QHP or advanced payment of premium tax credits and cost sharing reductions; and

- Optional delegation to the Exchange of Medicaid's responsibility to determine eligibility for non-MAGI populations.

Consistent with these policies, California's Exchange statute (AB 1602) mandates coordination of eligibility and enrollment processes between the California Health Benefit Exchange, the Department of Health Care Services, the Managed Risk Medical Insurance Board, and California's counties.

The proposed Exchange regulations further require that Exchanges must enter into such agreements with the Medicaid/CHIP agencies as are necessary to fulfill the requirements of the regulations. The Medicaid commentary suggests three broad ways in which States may design these agreements:

- one or more of the entities (the Exchange, Medicaid or CHIP agencies) could enter into an agreement whereby some or all of the responsibilities of each entity are performed by one or more of the others;

- a State could develop a fully integrated system whereby the responsibilities of all entities are performed by a single integrated entity; or

- each entity could fulfill its responsibilities and establish strong connections to ensure the seamless exchange of information and data.

Regardless of the specific approach a State takes toward integration of Medicaid with the Exchange, it will require a culture shift for State Medicaid agencies, and may create operational challenges, particularly in States like California where local governments play a significant role in Medicaid eligibility functions. Adding another potential level of complexity, California will need to contend with synchronizing across three agencies since Healthy Families is administered separately from Medi-Cal.

Streamlined Medicaid Program

The current Medicaid eligibility determination process is complicated for consumers and for States due to a patchwork of mandatory and optional eligibility groups and a multitude of financial and non-financial eligibility criteria and documentation requirements. The proposed regulations implement the streamlined Medicaid eligibility process contemplated in the ACA, collapsing existing Medicaid categories for children and families into three eligibility groups: children under 19, parents/caretakers and pregnant women. These groups and the newly created childless adult group under the ACA are eligible for Medicaid up to a floor of 133% of the FPL, as determined using the simplified MAGI income standard. The MAGI income standard

includes a statutory 5% percent across-the-board disregard and all traditional Medicaid income disregards and asset tests for MAGI populations are eliminated. Like other states, California will need to implement the MAGI income standard. In addition, California will need to eliminate the asset tests currently imposed on Medi-Cal adults.

Coverage Continuity

In an effort to minimize the risk of eligible individuals losing coverage, each of the Medicaid and Exchange regulations sets forth user-friendly redetermination (coverage renewal) processes that build on successful strategies States have used to increase retention rates, decrease churning and reduce administrative burdens in Medicaid.

The Exchange regulations provide that an Exchange must send a QHP enrollee an annual redetermination notice, including, where relevant, updated tax return and current household income data and the amount of any advanced premium tax credit payments or level of any cost-sharing reductions for which he or she would be eligible. The enrollee must sign and return the notice, including any corrections required. If the enrollee does not sign and return the notice, the Exchange will redetermine eligibility based on the eligibility information in the notice.

Unlike the Exchange, the Medicaid agency must first review eligibility for enrollees by evaluating information from electronic data bases (administrative renewal). If that information is sufficient to make a determination of eligibility, coverage shall be continued. If administrative renewal is not possible, then the Medicaid agency will send a pre-populated renewal form to the enrollee who will have 30 days to provide the additional information required to determine continued eligibility. The regulations seek comment on a potential 90-day grace period for return of the form. Medi-Cal does not currently employ administrative renewal and will therefore need to develop this process.

Verification of Eligibility and the Reasonably Compatible Standard

The ACA envisions a data-driven verification system in order to improve the application experience while maintaining strong program integrity. Both the Medicaid and Exchange rules require the use of electronic data and applicant/enrollee attestation in verifying eligibility information at enrollment and renewal to enable real time processing of applications for QHP and for Insurance Affordability Programs. Data sources include the Social Security Administration, the Department of Homeland Security and the IRS as well as State data sources, including those available to verify current income. Only if the Exchange or the Medicaid agency is unable to verify through these sources may documentation be requested from the applicant. Moreover, the proposed rules state that if the information provided by the individual is "reasonably compatible" with the electronic data or other information that the Exchange or Medicaid agency has obtained from other sources, no

further information may be requested of the applicant. According to the draft regulations, "reasonably compatible" does not mean that the information is identical, but rather generally consistent. As with many other aspects of the regulation, the verification requirements will be a significant culture change for many State Medicaid agencies that today rely heavily on paper documentation for verification of eligibility.

State Flexibility

While the proposed rules dictate new details on requirements for State Exchanges – and charge the Secretary with creating information systems, sampling methodologies and a model application to support implementation of these rules – they also offer States flexibility in implementing these policies. For example, State Exchanges may use different processes to obtain and verify individual eligibility information than those outlined in the proposed rules, provided that modifications reduce administrative burdens on individuals while maintaining accuracy, confidentiality, coordination and minimizing delay, and further provided that the Secretary approves the alternative process.

Relationship Between MAGI and Non-MAGI Populations

In addition to implementing the ACA goal of seamless coverage across the continuum of coverage for MAGI-eligible populations, the proposed regulations suggest a coordinated process by which individuals who may be eligible for Medicaid on a non-MAGI basis (e.g. disability) will be evaluated. If the Exchange or the Medicaid agency determines an individual ineligible for Medicaid based on the MAGI methodology, the reviewing agency must provide information to the applicant that they may be eligible for Medicaid on a non-MAGI basis. If an applicant pursues a standard Medicaid review, the proposed Medicaid regulations propose that this review occur at the same time as evaluation for potential eligibility for premium tax credits. If the Exchange is doing the review, it must promptly transmit any eligibility information collected as part of the MAGI review process to the Medicaid agency. The Medicaid regulations require the Medicaid agency to collect eligibility information necessary for the Medicaid agency to make a non-MAGI determination. It is unclear whether the Exchange will likewise be required to collect the additional information.

Enhanced Federal Matching Dollars for Newly Eligibles

The Medicaid proposed regulations codify the ACA provisions regarding enhanced FMAP for "newly eligible" adults in all States and for childless adults in expansion States. Accordingly, States will need to distinguish expenditures for newly eligible individuals from expenditures for individuals who would have been eligible for Medicaid (under the pre-ACA rules) as of December 1, 2009. HHS endeavored to identify an approach to FMAP calculation that would not undermine the ACA's eligibility simplification goals by requiring States to apply both old and new eligibility rules on a case-by-case basis. In the Medicaid regulations, HHS proposes three alternative

population-based methodologies that States may use for claiming the appropriate FMAP. Under the Section 1115 waiver, the State is currently phasing-in of coverage for adults who will be eligible for Medi-Cal under the new mandatory Medicaid category. This experience and advance identification of "newly eligible" individuals could help the State position itself more successfully to capture the maximal amount of enhanced FMAP when it becomes available in 2014.

IRS Rules

The proposed rules issued by the IRS define key concepts for determining eligibility for and paying the premium tax credits authorized by the ACA. The IRS rule provides the requirements and methodologies for calculating and reconciling premium tax credits, and articulates the roles and responsibilities of taxpayers, Exchanges and federal agencies in ensuring that the premium tax credit program is administered effectively. Most importantly, the rule provides myriad case examples to demonstrate administration of the tax credits that inform State Exchange operations and systems design. Notably, the rule provides significant new insight into the interactions of the premium tax credit program and employer and government sponsored minimum essential coverage, including references to future rule-making that will further clarify key aspects of the ACA.

Request for Comment

Finally, while proposed rules are, by nature, an invitation for public comment, the accompanying commentary of the two HHS proposed regulations repeatedly ask for State comment related to specific provisions of the rules, suggesting that the final rules may differ from or provide additional amplification to the draft guidance. In contrast, the IRS seeks few comments and where it does it is generally related to the information collection process and the clarity and quality of the information collected. Comments are due to both agencies by October 31, 2011. Comments must be submitted electronically, by mail, or by hand or courier. The IRS scheduled a public hearing on November 17, 2011 and an outline of topics to be discussed must be received by November 10, 2011.

II. ELIGIBILITY CRITERIA, ENROLLMENT PROCESSES AND VERIFICATION

This section provides an overview and analysis of eligibility criteria, enrollment processes and verification for the Exchange and Medicaid. The content is largely drawn from the Exchange proposed rule and the Medicaid proposed rule, with cross references to relevant provisions of the IRS proposed rules.

ELIGIBILITY CRITERIA FOR ENROLLMENT IN QHP OR INSURANCE AFFORDABILITY PROGRAMS

Eligibility for Enrollment in QHP (Exchange §155.305(a))

The Exchange proposed rules describe minimum eligibility criteria for enrollment in a QHP. Individuals eligible to enroll in a QHP through State Exchanges include those who are: (1) citizens or lawfully present immigrants; (2) not incarcerated; (3) residing within the Exchange service area[4]. Individuals meeting these criteria and choosing not to pursue tax credits may be enrolled in a QHP without further inquiry.

Eligibility for Enrollment in Insurance Affordability Programs (Exchange §155.305(c)-(h); Medicaid §435.603, §§ 457.300 through 320)

If requested by the applicant, an Exchange must determine eligibility for Insurance Affordability Programs. Because individuals eligible for Medicaid, CHIP or a Basic Health Plan are not eligible to enroll in a QHP, the Exchange is compelled to start with an eligibility review for these programs.

Advanced Payments Of Premium Tax Credits and Cost Sharing Reductions (Exchange §155.305 (f)-(h); IRS §§1.36B-2 (b)(5),(6); and §1.36B-2 (c))

An individual is eligible for advanced payments of premium tax credits if he or she is:

- a " primary taxpayer"[5] with income between 100% and 400% FPL;

[4] A tax dependent or spouse who lives outside the service area of the Exchange may seek coverage through either the Exchange that services the area in which the spouse or tax dependent resides or the Exchange that services the area in which the primary taxpayer resides. Exchange §155.305.

[5] The IRS proposed rules refer to an "applicable taxpayer," defined as a taxpayer who: (1) has income between 100 and 400% FPL; (2) if married, files joint tax return; and (3) is not claimed as a dependent by another taxpayer. The IRS regulations further note that while individuals not lawfully present in the US or individuals who are incarcerated are not eligible to participate in a QHP, they may be a applicable tax payer if a household member is eligible to enroll in a QHP. The

- claiming one or more individuals eligible to enroll in a QHP (see above);
- and who is not eligible for minimum essential coverage (MEC) through an employer–sponsored plan or government program.

The IRS proposed rule codifies the ACA provision that lawfully present individuals with incomes below 100% FPL are treated as applicable taxpayers eligible for premium tax credits if they or their family member are ineligible for Medicaid and they otherwise would be an applicable taxpayer if their income were between 100 and 400% FPL. The rule further clarifies that other taxpayers with incomes below 100% FPL for the taxable year may be treated as applicable taxpayers eligible for premium assistance if the Exchange estimates at the time of enrollment that the taxpayer's household income will be within the 100 to 400% FPL range for the taxable year.

The IRS proposed rule also codifies the ACA provision that individuals are ineligible for premium tax credits in any month that they are eligible for minimum essential coverage (MEC). As defined in section 5000A(f) of the Internal Revenue Code, such coverage includes government-sponsored[6] and employer-sponsored MEC. The proposed rule also provide significant new guidance with respect to the interactions between premium tax credit eligibility of minimum essential coverage eligibility. (MEC is further defined in Section III below.)

Finally, an individual who is eligible for advance payment of the premium tax credit will also be eligible for a cost sharing reduction if his or her household income is less than 250% FPL and is enrolled in a silver level plan (different and more generous cost sharing rules apply to American Indians and Alaska Natives.[7]

Expansion of Medicaid Coverage and Simplification of Medicaid Categorical Eligibility (Medicaid §§435.110, 435.116, 435.118, 435.119, 435.218; Medicaid Preamble II(A)(2) and (3))

The Medicaid proposed regulations codify ACA provisions that extend mandatory Medicaid coverage to non-disabled individuals under 65 with incomes up to 133% FPL.

Exchange regulations cross reference "primary tax payer" and "applicable tax payer" at §155.305 (f)(1)(i).

[6] Special Rule for Veteran's Coverage. The proposed rule provides that veteran's coverage is only deemed government-sponsored MEC (thus excluding an individual from premium assistance participation) if an individual is actually enrolled in such coverage.

[7] Under §155.350 of the Exchange regulations, Indians are eligible for cost sharing reductions up to 300% FPL and an Exchange must determine an applicant eligible for the special cost-sharing rules if he or she is an Indian without requiring the applicant to request an eligibility determination.

States also have the option to provide Medicaid coverage to individuals at even higher income levels, as long as the individual is not eligible for, or enrolled under, another Medicaid mandatory or optional eligibility category covered by the State, based on information in the individual's application. HHS notes in the preamble that this option is an alternative to use of income disregards, and that individuals who appear to be "medically needy" based on the information provided can also qualify for Medicaid coverage under this new optional category.

Approximately 850,000 childless adults with incomes under 133% FPL and 280,000 parents with incomes between 106% and 133% FPL are expected to become newly eligible for Medi-Cal. California has a head start on the Medicaid expansion after securing Section 1115 waiver authority to phase-in coverage, on a county-by-county basis, for adults ages 19-64 with incomes at or below 133% FPL. (Analysis by California Department of Healthcare Services)

In addition to the expansion to childless adults, the ACA streamlines the Medicaid eligibility floor for children of all ages to 133% FPL. In the commentary, HHS notes that States that are covering children ages 6-18 between 100%-133% FPL under a separate CHIP program would be expected to shift coverage of those children into Medicaid but would still retain the ability to claim federal funding at the enhanced CHIP FMAP.

In addition, the complex framework of existing Medicaid mandatory and optional eligibility groups for children and parents are collapsed into three main categories: (1) parents and caretaker relatives; (2) pregnant women; and (3) children. HHS notes these modifications are intended to simplify State administration and promote understanding by the public and are not meant to otherwise impact coverage eligibility.

California will also need to shift 162,000 children between ages 6-18 with family incomes between 100% and 133% FPL from Healthy Families to Medi-Cal coverage. The State is now presented with the opportunity to evaluate whether it will further expand coverage levels under Medi-Cal. (Analysis by California Department of Healthcare)

Definition of MAGI – Income and Populations (Exchange §155.305(c); Medicaid §435.603(a)-(e))

As provided under the ACA, all Insurance Affordability Programs will use a MAGI standard, set forth in the IRS rules, to determine income eligibility.[8] However, the Medicaid proposed regulations provide three exceptions to the MAGI income counting methodology for Medicaid: (1) lump sum payments

[8] The CHIP regulations propose full alignment to Medicaid eligibility rules including the application of MAGI and household definition as well as the proposed non-financial eligibility criteria. Medicaid Regulations § 457.300 through §457.320.

are counted in the month received; (2) educational scholarships or fellowships are excluded from consideration as income; and (3) certain types of income for American Indian/Alaska Native individuals are excluded. The Medicaid proposed regulations seek comments on the treatment of Social Security benefits which are not considered countable income under the IRS Tax Code but are considered income under Medicaid rules. Not counting Social Security benefits may result in individuals being eligible for Medicaid who otherwise would not be eligible.

The Medicaid proposed rules also codify the ACA's elimination of all income or expense disregards in Medicaid, replacing them with a 5% across-the-board increase in income eligibility.

The new Medicaid financial eligibility dates are effective January 1, 2014. For individuals recertifying their existing Medicaid coverage, the new financial methodologies will be effective March 31, 2014 or the next regularly scheduled redetermination, whichever is later.

Finally, the Medicaid proposed regulations codify the populations not subject to MAGI methodologies, including those who do not require a financial determination (e.g. SSI recipients), aged, blind or disabled populations, those eligible due to a need for long term care, those eligible for Medicare cost sharing, or those eligible under the Medicaid Medically Needy standard.

Budgeting Periods (Medicaid §435.603(h); Medicaid Preamble II(B)(1); Exchange §155.305((f)(1); IRS §1.36B-2(b)(1))

MAGI income determinations are based on current monthly income in Medicaid, while tax credits are based on annual incomes, paid in advance and reconciled at year end based on tax returns. From an operational perspective, this means that the Exchange must always determine eligibility first based on current income (for Medicaid), and if the individual is not Medicaid eligible, thereafter determine eligibility for premium tax credits based on estimated annual income.

The Medicaid proposed rules retain the current State flexibility to take into account future changes in income that can be reasonably anticipated (such as with certain seasonal workers or someone with an employment contract or layoff notice). States are further given the flexibility to maintain eligibility for current beneficiaries so long as the annual income based on MAGI methods for the calendar year remains at or below Medicaid standards. The Medicaid commentary notes that States that do not opt for this flexibility may encounter individuals who are both ineligible for Medicaid (because their current income is too high in a particular month) and ineligible for advanced payments of premium tax credits (because their income is below 100% FPL over the course of the year), and request comments regarding how to prevent such gaps.

Family and Household Definitions (Medicaid §435.603 (b) and (f); IRS §1.36B-1(d)-(e); Medicaid Preamble II(A)(3)(a)(1))

Family or Household definitions are important because they dictate whose income is counted for the purposes of applying for an Insurance Affordability Program. For the purposes of eligibility for tax credits, the IRS proposed regulations define a Family as those individuals for whom a taxpayer properly claims a personal exemption for a taxable year.

Under the Medicaid proposed rules, the household definition for those who file taxes generally starts with this tax filing unit, but provides for some Medicaid-specific exceptions. For example, the Medicaid proposed rule allows children living with caretaker relatives, such as grandparents, to apply for Medicaid without consideration of the relatives' income. The commentary notes that alignment of this Medicaid rule with the IRS definition of family would risk disrupting coverage for children and increasing financial obligations for grandparents and other caretaker relatives. When non-custodial parents claim children as a tax dependents, the proposed rule preserves existing Medicaid policy which considers children part of the households in which they reside. The Medicaid proposed rules also maintain the policy of counting pregnant women as two people. Finally, the rules require non-married parents living with their children, and all married couples living together to be included in the household regardless of whether they file a joint return.

For families who do not file taxes, the Medicaid proposed rules define the household as consisting of the applicant as well as any spouse and children or step children living with the applicant. If the applicant is a child, any minor sibling or step-sibling or parents or step-parents residing with the applicant also must be included. Finally, the Medicaid proposed rule makes changes to the treatment of 19 and 20 year olds living with their parents to move the rules closer to IRS rules, but do not go so far as to create full alignment. In short, 19 and 20 year olds are counted in the household only if living at home and a full time student.[9]

> *The requirement that step-children, step-parents and step-siblings be counted as members of Medicaid households is a departure from previous Medi-Cal household rules, and is likely to result in a small number of families losing Medicaid coverage.*

Citizenship and Immigration (Exchange §155.305(a)(1)5, Exchange Preamble II(A)(1)(b))

As noted above, the Exchange proposed rules codify the ACA requirements that low-income, lawfully present individuals who are ineligible for Medicaid may enroll in QHPs through the Exchange and apply to receive premium tax credits. The proposed rules require the Exchange to follow Medicaid rules

[9] CHIP related regulations fully align CHIP eligibility rules to those articulated for Medicaid and eliminate the CHIP asset test. ***Medicaid §§ 457.300 through 320.***

with respect to the definition of lawfully present immigrants. The proposed rules do not change the requirements for citizenship and immigration status for Medicaid and CHIP, which limit coverage to citizens and a federally defined subset of lawfully present immigrants.[10]

Residency (Exchange §155.305, Medicaid §435.403)

The Exchange proposed regulations establish a residency requirement in the state "within the service area of the Exchange." Medicaid maintains residency as a condition of eligibility. Under both proposed rules, residency is determined based on where the individual is living and has "intent to reside." The new "intent to reside" standard is a departure from current Medicaid requirements that the individual reside "permanently or for an indefinite period." The Medicaid proposed rules also change the residency requirement for children by de-linking a child's residency from that of their parents. The commentary reasons that such a change assists families where parents and children might not be living in the same state, such as migrant and seasonal workers. States maintain flexibility in establishing student residency requirements.

ELIGIBILITY DETERMINATION PROCESSES

Coordination between QHP and Insurance Affordability Program Eligibility Processes (Exchange §155.345; Medicaid §435.1200)

The Exchange must assess eligibility for QHP enrollment for individuals who do not seek financial subsidies to purchase coverage. Additionally, the Exchange and Medicaid/CHIP agencies have parallel and concomitant obligations to assess eligibility for all Insurance Affordability Programs for those individuals seeking subsidies. As a general rule, applicants may not be asked to provide information beyond what is necessary to support the eligibility and enrollment processes of the Exchange, Medicaid and CHIP.

Single Application (Exchange §155.310(a); Medicaid §435.907)

The proposed rules align with requirements of the Exchange rule issued in July 11, 2011 (CMS 9989-P) that require that States utilize either a federal model single streamlined application for all Insurance Affordability Programs, or an alternative State-specific form for which the State has received federal

California's recent experience with streamlined, electronic applications, such as County One-e-App and Health-e-App, will be helpful to inform state planning. These forms could serve as the basis of a State-specific form, should California choose to tailor the application beyond the federal model. Face-to-face interview requirements have been eliminated in California.

[10] CHIPRA gives states the option of lifting the five year bar for children and pregnant women.

approval.[11] The Medicaid regulations provide that States may use alternative or supplemental application forms for non-MAGI Medicaid populations, but such forms also must be federally approved. Finally, the Medicaid proposed regulations permit explicitly, for the first time, electronic, telephonic and facsimile signatures. The commentary notes that States may not require a face to face interview for Medicaid applicants. Currently, two States have face-to-face requirements for children and seven States have face-to-face requirements for adults.[12]

Coordination with MAGI-Exempt Categories (Exchange §155.345 (b), Exchange Preamble II(A)(1)(c); Medicaid § 435.911, Medicaid Preamble II(E))

The proposed Exchange and Medicaid regulations require the Exchange to collect eligibility information (by using the uniform application and supplemental forms or an alternative Secretary approved application) and electronically transfer information to the Medicaid agency on applicants who may be eligible for Medicaid in a MAGI-exempt category such as disability. The Exchange commentary notes that while the responsibility of eligibility determinations for non-MAGI populations remain with a Medicaid agency, a State may choose to establish an eligibility system that conducts all eligibility determinations for the Exchange, BHP (where applicable), Medicaid and CHIP, including those Medicaid determinations that are based on factors beyond the MAGI-based income standards, as long as the state is compliant with Single State Agency requirements. The Medicaid commentary notes that the non-MAGI evaluation must occur simultaneous to the eligibility determination for premium tax credits. As discussed in a later section, the proposed Exchange and Medicaid regulations assume real time eligibility determinations when possible. however more specific timeframes are not defined. The Medicaid commentary notes that HHS will be developing performance standards and metrics in collaboration with States.

Eligibility Rules and Administration of Advance Payments of the Premium Tax Credit (Exchange § 155.310, § 155.340))

An individual eligible for advance payments may opt to receive less than the full amount for which he or she is eligible.

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[11] The CHIP regulations propose to align CHIP application and enrollment processes with other Insurance Affordability Programs, including a single, streamlined application, availability of information on the shared Website, coordinated verification procedures, and the State's obligation to provide application assistance in-person, online, or by telephone. Medicaid Regulations §457.335 through §457.380.

[12] Haberlein, M., Brooks, T., and Guyer, J., "Holding Steady, Looking Ahead: Annual Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP," 2010-2011, Georgetown University Center for Children and Families and Kaiser Commission on Medicaid and the Uninsured (January 2011)

To support the employer responsibility requirements of the ACA, the Exchange must notify the employer when an employee is determined eligible to receive advance payments of the premium tax credit or cost sharing reductions based in part on a finding that the employer does not provide MEC that meets the minimum value standard and is affordable.

If an applicant is found eligible to enroll in a QHP but fails to do so within the open enrollment period[13] and later seeks to enroll, the Exchange proposed rules allow the applicant to enroll as long as it is before the annual redetermination date, and the eligibility information is up to date or updated. To the extent that the applicant seeks to enroll on or after the date on which he would have been redetermined, the Exchange must follow the procedures outlined in the annual eligibility determination section.

The Exchange proposed regulations require the Exchange to provide information about an enrollee's eligibility for, and the amount of, any advance payments of premium tax credits and cost-sharing reductions to the applicable QHP and to HHS to enable advance payments. Where the Exchange determines that an individual is eligible for advance payments and cost-sharing reductions based in part on a finding that an individual's employer does not provide affordable MEC meeting minimum value requirements, the Exchange must transmit the enrollee's name to HHS to facilitate the employer responsibility provisions of the ACA. The Exchange further must report information to enable the Secretary of the Treasury to reconcile the amount of advance payments received by an individual with the amount allowed based on his or her tax returns.

Eligibility Determination Timeframes (Exchange Preamble II(A)(1)(d); Medicaid §435.952, Medicaid Preamble II(G)(4))

The proposed Exchange and Medicaid regulations assume real time eligibility determinations. The Medicaid proposed regulations eliminate current 90 and 45-day processing timeframes for disabled and non-disabled applicants, respectively.

Exchange Authority to Make Medicaid Eligibility Determinations (Exchange §§155.305(c) and 155.345, Exchange Preamble II(A)(1)(j); Medicaid §431.10(c), Medicaid Preamble II(J))

The Exchange proposed rules require the Exchange to determine eligibility for certain Medicaid applicants. The commentary anticipates that Medicaid and CHIP eligibility determination activities conducted by the Exchange will be conducted in cooperation and

The regulations are silent on how Exchanges that are quasi-governmental entities are to be treated. With the California Health Benefit Exchange operating as an independent public entity, this is one area that California will need to seek further clarification from HHS.

[13] The open enrollment period is defined in the Exchange Establishment NPRM issued on July 11, 2011.

coordination with the program agencies and eligibility systems. To align with this requirement, the Medicaid proposed rules modify existing regulations to add government-operated Exchanges as one of the entities to which State Medicaid agencies may delegate Medicaid eligibility determinations for MAGI populations. With regard to privately operated Exchanges, HHS solicits comment on whether such entities should be permitted to conduct Medicaid eligibility determinations and other approaches for privately operated Exchanges to fulfill the ACA's eligibility coordination mandate. HHS suggests possible co-location of State Medicaid eligibility workers at private Exchanges. Commentary to the Exchange rules also notes that the Exchange may facilitate delivery system or health plan selection for Medicaid and CHIP, including transmitting enrollment transactions to health plans, if the agencies administering Medicaid or CHIP enter into an agreement with the Exchange to perform this function.

Medicaid Coverage Months (Medicaid Preamble II(F))

As a result of new Exchange effective date rules, if Medicaid eligibility is discontinued and coverage is not extended to the end of the month a consumer may face a coverage gap of at least a month until their QHP enrollment is effective. The commentary invites feedback on whether HHS should promulgate a rule requiring Medicaid coverage to extend to the end of the month in order to align with Exchange coverage rules.

REDETERMINATION PROCESSES

Interim Eligibility Redeterminations (Exchange §155.330, Exchange Preamble II(A)(1)(f))

The Exchange proposed regulations place the primary burden on enrollees to report – within 30 days – changes with respect to their eligibility for advanced payment of premium tax credits or enrollment in a QHP. In addition, the Exchange must also periodically examine electronic data sources to identify death and eligibility determinations with respect to Medicaid, CHIP or BHP. Generally, changes resulting from a redetermination are effective on the first day of the month following the date of the notice of redetermination. Reflecting the concern that individuals avoid large repayment obligations, HHS solicits comments as to whether there should be an additional role for Exchange-initiated data matching and enrollee reminders to report changes. While the consequences are different, Medicaid has similar reporting obligations.

Annual Redeterminations (Exchange §155.335; Medicaid §435.916)

The Exchange must re-determine the eligibility of a QHP enrollee annually and must request tax return data with respect to individuals receiving advance payments of premium tax credits. The Exchange must provide the enrollee with an annual redetermination notice with the updated household income information and the enrollee's projected eligibility for the following year, including, where applicable, the amount of any advance payments of

the premium tax credit and the level of cost-sharing reductions. The enrollee must sign and return the notice within 30 days, reporting any changes relative to the information reported on the notice. If the enrollee fails to return the notice, the Exchange will re-determine the individual's eligibility based on the information provided in the notice. However, the IRS rule notes that individuals who received premium tax credits in the previous taxable year, but failed to file a tax return, are ineligible for ongoing premium tax credits until they file taxes.

Similarly, the Medicaid proposed rule requires a 12-month recertification period for MAGI populations. The majority of States already have such an annual redetermination process but two States will be required to align their redetermination policies from six months to 12 months for children and six States will need to extend recertification for adults.[14]

The Medicaid proposed rule establishes a Medicaid administrative renewal process requiring State Medicaid agencies to use available databases for eligibility verification. Every 12 months, the State agency will be required to conduct back end verification using existing information available to the agency. The State agency will then notify the individual that they have been found eligible for Medicaid and the basis of their determination. The individual is required to notify the agency (online, by phone, by mail, in person, or by fax) if any information is inaccurate but is not otherwise required to take action (no signature or return of the notice if the information is accurate). If a State agency is unable to determine Medicaid eligibility through administrative renewal, the agency is required to send a pre-populated recertification form. The recipient is given 30 days to recertify. The commentary notes that Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) regulations will be modified to reflect these proposed changes to redeterminations.

With all individuals that enroll in QHP (with or without a subsidy), Medi-Cal or Healthy Families required to have their eligibility redetermined annually, this is an area where the State will need to coordinate the work of Medi-Cal, MRMIB and the Exchange, and may want to enter into formal agreements to consolidate the required work.

VERIFICATION

Attestation and Electronic Verification (Exchange §§155.315 and 155.320; Medicaid §§435.945, 435.948, 435.952)

Under both Medicaid and Exchange proposed rules, most eligibility criteria (income, residency, eligibility for or enrollment in other coverage, household size, pregnancy, birth date) may be verified by a combination of attestation and/or verification through electronic databases. The Exchange proposed rule provides that where information is inconsistent or cannot be verified, the

[14] Supra note 12.

applicant must be able to enroll in a QHP, with appropriate tax credits, and given 90 days to verify the information in question, with limited exceptions. The Exchange may extend the period beyond 90 days where the applicant has made a good-faith effort to obtain documentation. In such cases, an applicant must attest that he or she understands that any advance payment is subject to reconciliation and possible repayment.

California currently requires documentation of identity, income, residency, immigration and certain deductible expenses for Medi-Cal and Healthy Families applicants.

The Medicaid proposed rule, as with the Exchange rule, provides that reasonable time should be given to resolve discrepancies. The Medicaid proposed rules also provide that nothing in the regulations limit State program integrity measures or effect the State's obligation to ensure only eligible individuals receive benefits.

Data Sources for Electronic Verification (Exchange §155.315; Medicaid §§ 435.948 and 435.949)

The regulations formally establish the "federal hub" for electronic verification of Insurance Affordability Program eligibility criteria through the Social Security Administration (SSA), the Department of Treasury, the Department of Homeland Security and any other agency that may be appropriate. They also codify the role of HHS as an intermediary between the Exchange and the Federal agencies. State Medicaid/CHIP agencies as well as the Exchange are required to use information available through the federal hub for verification of eligibility information. Finally, the Medicaid proposed regulations require State Medicaid agencies to establish a verification infrastructure using State and Federal agency data. For example, State Medicaid agencies may conduct electronic data matches to obtain income information from the State quarterly wage reports and Unemployment Insurance Benefits, the IRS and the SSA to verify financial eligibility. State Medicaid agencies have the discretion to determine which data sources to rely on, subject to approval by the Secretary.

An Exchange and a State Medicaid agency may use a different process to obtain and verify information provided HHS finds that any modification would reduce administrative burdens on individuals while maintaining accuracy, confidentiality and minimizing delay and that the alternative process would not undermine coordination with Medicaid and CHIP.

Reasonably Compatible Verification (Exchange §§155.315 and 155.320, Exchange Preamble II(1)(A)(1)(d); Medicaid §435.952, Medicaid Preamble II(G)(4))

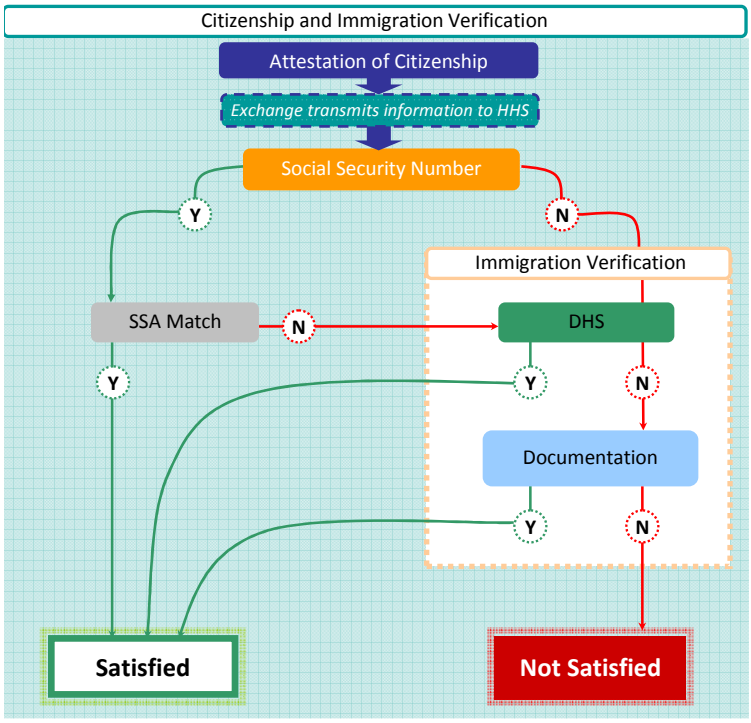
The proposed rules introduce a new "reasonably compatible" standard, applicable to eligibility determinations for QHP and Insurance Affordability Programs, that prohibits the Exchange or the Medicaid agency from requesting additional documentation if the information available through

electronic data matching is "reasonably compatible" with information provided by the applicant. The Medicaid commentary explains that "reasonably compatible" does not mean an identical match but that information is generally consistent, and goes on to note that States will have flexibility in applying this standard because reasonable compatibility will vary depending on circumstances. The Exchange commentary indicates an intent to apply the same interpretation in the context of Exchanges.

COMPARISON OF EXCHANGE AND MEDICAID RULES AND PROCESSES FOR VERIFICATION

Citizenship/Immigration Status (Exchange §155.315; Medicaid §435.945)

For enrollment into a QHP, the Exchange must verify citizenship or lawfully present status by either matching the applicant's Social Security number (SSN) with the Social Security Administration (SSA), matching documentation through the Department of Homeland Security (DHS) or, if neither data match is successful, providing "satisfactory documentary evidence" which is the existing documentation standard under Medicaid/CHIP.



For enrollment into Medicaid/CHIP, the proposed regulations do not change the current rules regarding verification of citizenship or immigration status.

Residency (Exchange § 155.315; Medicaid §435.956)

For enrollment in a QHP, with limited exceptions, the Exchange must accept an applicant's attestation of residency without further verification. For enrollment into Medicaid/CHIP, States have flexibility in determining whether they will accept attestation of residency or whether they will require additional verification through data sources. As such, if the Medicaid agency chooses to examine electronic data sources to verify residency, the Exchange must follow those procedures for those individuals seeking an eligibility determination for Insurance Affordability Programs.

Pregnancy (Medicaid §435.956)

Exchange rules are silent as to verification of pregnancy. The Medicaid regulations propose a new rule requiring States to accept self-attestation of pregnancy without electronic verification.

Incarceration (Exchange §155.315)

The proposed rules require the Exchange verify through electronic data sources that an applicant is not incarcerated. The Medicaid proposed rules are silent on this topic.

Minimum Essential Coverage Other Than Employer Sponsored Plan (Exchange § 155.320)

The Exchange must determine any other non-employer coverage for which the applicant is eligible. The preamble notes that the Exchange should be able to obtain data through HHS to determine if an individual is eligible for MEC other than through an employer-sponsored plan or Medicaid, CHIP or BHP. An example would be veterans health coverage. HHS is working with other federal agencies to identify the location of relevant records and solicits comments on specific data sources that HHS should integrate into this process.

Household Income and Household Income (Exchange § 155.320, Medicaid §435.935, §435.948)

The Exchange must accept an applicant's attestation oh household income unless such information is not reasonably compatible. The Exchange must compute annual household income by first obtaining tax data from the IRS and then having the applicant attest, on a real time basis, that the tax return data represents an accurate projection of the family's income for the benefit year. The preamble notes that this reverses the process contemplated in the ACA which had the applicant first provide his/her MAGI and the Exchange verifying that information with IRS. If the applicant attests that the income for the benefit year will be **higher** than reflected on the tax return, the Exchange generally must accept the attestation. If the applicant attests that the income for the benefit year will be **lower** than reflected on the tax return, the regulations provide an alternative verification process which use other data sources and documentation. This alternative process also applies

if the IRS does not have tax data, if the applicant has filed for unemployment benefits or if the applicant attests that the primary tax payer's applicable family size has changed. As described above, the applicant will have 90 days to verify income and family size through this process.

For enrollment into Medicaid/CHIP the Exchange must accept an applicant's attestation of income unless not reasonably compatible. Verification of a household's MAGI-based income is based on current income and States must verify information through: (1) other state and federal agencies; (2) databases with information related to wages, net earnings from self-employment, unearned income and resources; and (3) the Public Assistance Reporting Information System, SNAP and other Insurance Affordability Programs. States may use alternative databases so long as they reduce administrative burdens on individuals while maintaining accuracy, confidentiality and minimizing delays. The Secretary must approve such alternatives.

Because a determination of Medicaid ineligibility is a prerequisite to eligibility for advance payment of premium tax credits and cost sharing reductions, the Exchange must determine current as well as projected annual income for an applicant and must apply Medicaid's definition of household and income, as well as those for the Exchange. The preamble seeks comments as to how the Exchange and Medicaid processes can be streamlined to ensure consistency and maximize the number of eligibility determinations that can be completed in a single session.

Employer Sponsored Plan (Exchange § 155.320)

An individual is eligible for advance payments/cost-sharing reductions if he or she is not eligible for qualifying coverage in an eligible employer sponsored plan that meets a minimum value standard and is affordable under IRS regulations. The Exchange proposed regulations state that an individual must attest, and an Exchange must verify, whether the individual is eligible for qualifying coverage in an eligible employer-sponsored plan. The preamble goes much further, noting that HHS and the Departments of Treasury and Labor are working together to coordinate how needed information could be reported efficiently to minimize the burden on employers and employees. Among other things, the agencies are considering a template to capture the relevant information from employers and employees, and the feasibility of a central database that employers could populate. Comment is sought on the timing and reporting of information needed to verify an applicant's eligibility for qualifying coverage in an employer-sponsored plan.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) FOR NEWLY ELIGIBLE INDIVIDUALS AND FOR EXPANSION STATES

Availability of FMAP (Medicaid §433.10(c))

The Affordable Care Act provides a Federal Medical Assistance Percentage ("FMAP") for coverage of adults determined "newly eligible" under the new mandatory Medicaid eligibility category beginning January 1, 2014. In addition to the enhanced FMAP available to States newly offering Medicaid coverage to adults up to 133% FPL in 2014, the ACA also extends an enhanced FMAP to those States that already offered health coverage to adults up to at least 100% FPL at the enactment of the ACA ("expansion States").

Newly Eligible FMAP (Medicaid §433.10(c)(6))

The proposed rule codifies the ACA's definition of "newly eligible" and the enhanced FMAP schedule. Consistent with the statute, "newly eligible" individuals are those who would have been *ineligible* for Medicaid under a State's Medicaid eligibility standards and methodologies – whether implemented under the State Medicaid plan or waiver demonstration program – in effect as of December 1, 2009. The enhanced FMAP will be available at 100% federal financial participation ("FFP") from calendar years 2014 through 2016 and phased down to 90% FFP for calendar years 2020 and beyond.

Expansion State FMAP (Medicaid §433.10(c)(7)-(8)))

The proposed rule also codifies the ACA provision that makes the enhanced FMAP available for childless adults in States that offered health coverage to parents and childless adults with incomes up to 100% FPL prior to enactment of the ACA . For expansion States, the enhanced FMAP is calculated in accordance with a formula articulated in the statute, which applies a "transition percentage" against the difference between the newly eligible enhanced FMAP rate for the year and the State's base FMAP:

Expansion State FMAP	=	Expansion State's Base FMAP	+	(Transition Percentage	x	(Newly Eligible FMAP	-	Expansion State's Base FMAP))

The transition percentage starts at 50% in calendar year 2014 and increases annually until it reaches 100% in calendar years 2019 and beyond. Therefore, in contrast to the newly eligible FMAP, the expansion State FMAP phases upward from 2014 to 2019. Both the expansion State FMAP and newly eligible FMAP equalize at the 90% level in 2020 and beyond.

Methodology (Medicaid §433.206(a)-(b), Medicaid Preamble II(N))

States may only access the enhanced FMAP for "newly eligible" individuals and, in expansion States, childless adults. In the preamble to the proposed rule, HHS discusses the complexities for the States and federal government as well as potential burdens for Medicaid applicants in determining the appropriate FMAP level (i.e., regular FMAP, newly eligible FMAP, or expansion State FMAP). HHS proposes three alternative methodologies from which States may select to make the determination and claim the appropriate FMAP for qualified expenditures:

- 2009 Eligibility Standard Threshold – States would apply December 1, 2009 eligibility criteria in a simplified manner, convert these criteria/standards into MAGI-equivalent standards, as well as consider proxies for other eligibility criteria (e.g., disability status and asset value), to determine whether an individual would be considered "newly eligible." In the preamble, HHS discusses consideration of disability status and use of proxies based on the receipt of SSDI, screening questions included in the Medicaid application, or retroactive claims review identifying individuals with significant medical problems. HHS also contemplates forgoing proxies and using only actual disability determinations and specifically requests comments on whether a disability proxy should be applied;

- Statistically Valid Sampling Methodology – States would use a statistically valid sample of Medicaid individuals and their related expenditures to extrapolate the expenditures for which States would receive the enhanced FMAP. States would sample on an annual basis for the first consecutive three years they implement this methodology and on a three year basis in the following years; and

- Use of FMAP Methodology Based on Relative Data Sources – States would use estimates of newly eligibles developed by CMS using reliable data sources (e.g., Medical Expenditure Panel Survey or State Medicaid Statistical Information System). Under this methodology, CMS would develop a model to predict the appropriate proportion of expenditures that each State may claim for newly eligible individuals and publish these data annually.

These three methodologies are discussed at length in the proposed regulations. The proposed rule requires that States notify CMS of their method selection no later than December 31, 2012 and utilize this method for three consecutive years before being permitted to change to another methodology.

HHS specifically requests comments on these three approaches and also whether HHS should maintain the approach of offer States the opportunity to choose or whether HHS should designate one single method for States to use. In the preamble, HHS notes that it plans to test these methodologies

further with States and possibly other methodologies as may be suggested through the comment process. In addition, HHS specifically articulates that it is not providing the option for States to maintain double eligibility systems and complete a determination for each individual under "obsolete eligibility rules" for purposes of determining the appropriate FMAP as it does not believe this would necessary or efficient.

SHOP PARTICIPATION (EXCHANGE PART 157)

The Exchange regulations propose standards that address qualified employer participation in SHOP. For the most part, these standards codify the ACA and mirror or complement the rules published in July, or uses terms defined in other parts of the proposed rule.

In brief, only qualified employers as defined in section 155.710 may participate in the SHOP and a qualified employer may continue to participate in the SHOP if it ceases to be a small employer. A qualified employer must abide by the rules of the SHOP including providing information to its employees about the enrollment process and timing. New employees hired outside of the initial or annual enrollment period must be given the opportunity to seek coverage in a QHP beginning on the first day of employment. Qualified employers must provide the SHOP with information on the eligibility status of new employees or employees whose status for coverage purchased through the employer has changed.

PRELIMINARY REGULATORY IMPACT ANALYSES OF MEDICAID AND EXCHANGE RULES

Medicaid Eligibility Proposed Rule (Medicaid Preamble V.C)

The commentary on the Medicaid proposed rule includes a summary analysis of implementation benefits and costs, based on CMS' detailed Preliminary Regulatory Impact Analysis (PRIA).[15] This preliminary impact analysis uses estimates produced by: the CMS Office of the Actuary (OACT), the Congressional Budget Office (CBO) and staff of the Joint Committee on Taxation.

Medicaid Eligibility and Enrollment

The proposed rules would result in an estimated additional 16 to 24 million newly eligible and currently eligible individuals enrolling in Medicaid and CHIP by 2016.

State Benefits

[15] Preliminary Regulatory Impact Analysis (PRIA), available at http://www.cms.gov/MedicaidEligibility/downloads/CMS-2349-P-PreliminaryRegulatoryImpactAnalysis.pdf

The proposed rule would benefit States and providers by reducing uncompensated care costs, shifting spending on State-funded health coverage and uncompensated care to the Federal government. Additionally, the simplified Medicaid eligibility policies proposed in the rule would reduce administrative burdens on State Medicaid agencies.

Federal Spending

Federal spending on Medicaid for newly and currently eligible individuals who enroll as a result of the changes made by the Affordable Care Act would increase by a total of $162 to $202 billion from 2012 through 2016.

State Expenditures and Savings

It is estimated that State expenditures on behalf of the additional population gaining Medicaid coverage as a result of the ACA will total $2.7 billion in FY 2014, $4.0 billion in FY 2015, and $4.9 billion in FY 2016. These estimates do not account for State savings from reductions in uncompensated care, less need for State-financed health services and coverage programs, and greater efficiencies in the delivery of care. The commentary points to the Urban Institute's findings that as a result of the ACA, States will see net savings of $92 to $129 billion from 2014 to 2019.

The proposed rule invites comments on its potential economic impact.

Exchange Eligibility Proposed Rule (Exchange Preamble IV.C)

The Exchange proposed rule's commentary also includes a summary analysis of implementation benefits and costs.

Benefits

The simple eligibility processes proposed in the rule would increase take-up of health insurance, leading to improved health. Also, the use of electronic records for eligibility verification would minimize transaction costs of purchasing coverage.

Costs

The costs of building or modifying IT systems to enable the new eligibility and enrollment process envisioned in the proposed rule, in addition to administrative costs to support this vision, will vary depending on a number of factors, including States' level of maturity of current systems and current governance and business models. Costs will also be dependent on State approaches to system design. Overall administrative costs may increase in the short term as States are building new systems, but States will see long-term savings related to more efficient systems.

The commentary notes that costs for the development of Exchange IT infrastructure are fully funded by the federal government through State Exchange Planning and Establishment Grants. Costs for IT infrastructure that

will also support Medicaid must be allocated to Medicaid and are eligible for an enhanced federal matching rate.

III. MINIMUM ESSENTIAL COVERAGE, PREMIUM ASSISTANCE COMPUTATION AND INFORMATION REPORTING

The ACA allows for advanceable and refundable premium tax credits to help individuals and families purchase QHP coverage in State Exchanges. The tax credits are designed on a sliding scale basis to reduce taxpayers' out-of-pocket premium costs, thus making health insurance coverage more affordable. The ACA further provides for advance determination of tax credit eligibility by State Exchanges. Taxpayers may receive advance payments of credits, paid on a monthly basis to the QHP in which they are enrolled. The law specifies that advance payments will be reconciled with actual credits for the tax year.

GOVERNMENT-SPONSORED MINIMUM ESSENTIAL COVERAGE

Definition of Eligibility for Government-Sponsored MEC (IRS §1.36B-2 (c)(2)(iii)(A))

The proposed rule provides that individuals are deemed eligible for government-sponsored MEC on the first day of the first full month in which they may receive benefits. The implications of this eligibility definition are significant in that individuals who are determined technically eligible for government coverage, but are not able to use such benefits due to delays in coverage activation, remain eligible for premium tax credits until they are able to use their government-sponsored health insurance. The proposed rule clarifies that individuals who fail to complete the requirements necessary to enroll in government-sponsored MEC (i.e., fail to select a health plan, if required) are treated as eligible for government-sponsored MEC on the first date of the second calendar month following the event which established their eligibility for government-sponsored health insurance.

Interaction Between Retroactive Medicaid Coverage and Premium Assistance Payments (IRS §1.36B-2 (c)(2)(iii)(B), IRS Preamble §1(b(i))

The regulation and accompanying commentary provide new guidance that individuals receiving advance premium credit payments who subsequently become eligible for government-sponsored MEC that is effective retroactively (e.g. Medicaid) are treated as eligible for the government-coverage no sooner than the first day of the first calendar month after the approval.

EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE

The proposed rule codifies the ACA provision that employees and related individuals who may enroll in an "eligible employer sponsored plan" – meaning a plan that is both affordable and meets a minimum actuarial value

standard – are eligible for minimum essential coverage and therefore ineligible for premium tax credits.

Definition of Employer-Sponsored MEC Plan Year (IRS §1.36B-2 (c)(3)(ii))

The proposed rule defines the plan year as the employer-sponsored plan's regular 12-month coverage period, or the remainder of the coverage year for employees who enroll during a special enrollment period.

Definition of Eligibility for Coverage Months During a Plan Year (IRS §1.36B-2 (c)(3)(iii))

The proposed rule defines eligible coverage months under employer-sponsored minimum essential coverage as any month during the plan year for which the employee or related individual could have been covered if he or she had enrolled in an open or special enrollment period. Pursuant to the examples provided in the rules, this means that if an employee or related individual forgoes enrollment in an eligible employer-sponsored plan, he or she is deemed ineligible for premium tax credit payments.[16] The commentary notes that this is true even in cases where the employers' enrollment period has closed.

Affordability Test For Employer-Sponsored MEC (IRS §1.36B-2 (c)(3)(v)(A)(1))

The proposed regulations provide new insight into the affordability test for employer-sponsored plans. Pursuant to the ACA, employees who have access to employer-sponsored coverage may decline enrollment and apply for premium assistance to purchase a QHP in the Exchange if their out-of-pocket premiums for the employer plan exceed 9.5% of their household income. However. the proposed rule clarifies that the basis for this affordability calculation is the cost of ***self-only coverage*** and applies to individuals related to the employee who are eligible to enroll in the employer plan. As such, even if a taxpayer requires family coverage, the employer plan is deemed "eligible" MEC if the cost of self-only coverage is less than 9.5%. The affordability test for premium tax credits as defined in the proposed rule will likely mean that some families will remain without access to affordable health insurance coverage in 2014.

Affordability Test for the Individual Responsibility Requirement (IRS Preamble §1(b)(ii)(B))

The commentary to the proposed rule suggests that future rule making is expected to establish a different affordability test to determine whether individuals related to employees are subject to the ACA individual mandate.

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[16] The rule clarifies a special rule for individuals who are eligible for continuation coverage (COBRA) as eligible for MEC only if the individual actually enrolls in such coverage. The availability of COBRA coverage does not constitute eligibility for MEC, only the enrollment in such coverage does.

Specifically, the individual mandate affordability test will be based on the cost of family coverage (versus self-only coverage) in an employer plans. Therefore if the cost of family coverage in an employer-sponsored plan exceeds 8% of the household income, such coverage would be deemed unaffordable for purposes of applying the individual mandate.

Employee and Employer Safe Harbor (IRS §1.36B-2 (c)(3)(v)(A)(2))

The proposed rule provides a safe harbor for employees who were offered eligible employer coverage that proves to be affordable based on household income for the taxable year, but who declined such coverage because it was deemed unaffordable by the Exchange at the time of enrollment. The safe harbor extends from the time of affordability determination until the end of the employer plan year; therefore, this timeframe may represent part-year periods and partially coincide or overlap with the taxable year for premium tax credits.

The ACA stipulates that large employers are subject to penalties to the extent that one or more of their full time employees are deemed eligible for premium tax credits. Commentary to the proposed rule notes that future rulemaking is expected to create an employer safe harbor with respect to offering affordable health insurance coverage. Specifically, employers will not be subject to the penalty if the employee portion of the self only premium for the employers' lowest cost plan does not exceed 9.5% of the employee's wages (versus the employees' household income, which employers have argued they have no way of knowing.)

Minimum Value (IRS §1.36B-2 (c)(3)(vi))

The rules codify the ACA requirement that eligible employer-sponsored plans provide minimum value, defined as a plan share of at least 60% of the total allowed costs of benefits.

COMPUTING THE PREMIUM ASSISTANCE CREDIT AMOUNT

The proposed rule defines a taxpayer's premium tax credit as the sum of "premium assistance amounts" for each coverage month in the taxable year.

Premium Assistance Amount (IRS §1.36B-3 (d))

The proposed rule provides the method for calculating premium assistance amounts. Such method is based on a number of factors including: household income, family size, "applicable percentage" (the taxpayer's required share of premiums based on household income), the "benchmark plan premium" (the premium for the second lowest cost silver plan in the Exchange), and the premium for the plan in which the taxpayer enrolls.

Premiums Paid on a Taxpayer's Behalf (IRS §1.36B-3 (c)(2))

The proposed rule notes that premiums paid by another person for coverage of the taxpayer, taxpayer's spouse or dependent are treated as paid by the

taxpayer. Examples clarify that in cases where another person pays premiums on behalf of a taxpayer or taxpayer's family, the tax credit still is claimed by and accrues to the benefit of the taxpayer.

Adjusted Monthly Premium (IRS §1.36B-3 (e))

The proposed rule defines the adjusted monthly premium as the amount the issuer would charge for the applicable benchmark plan to cover all members of the taxpayers family, adjusted for age of each member of the coverage family.

Applicable Benchmark Plan (IRS §1.36B-3 (f))

The proposed rule defines the applicable benchmark plan for the purposes of premium assistance calculation as the second lowest cost silver plan that would cover the coverage family and is offered at the time the taxpayer's family members enroll. An applicable benchmark plan could be self-only coverage or family coverage.

Applicable Percentage (IRS §1.36B-3 (g))

The proposed rule codifies the ACA sliding scale used to determine the taxpayer's required share of premiums for the benchmark plan. The percentage scale, ranging from 2% of income for families with incomes less than 133% of FPL to 9.5% for families with incomes over 300% of FPL, is applied to the taxpayer's household income. This amount is subtracted from the adjusted monthly premium in calculating the premium assistance amount.

QHP Covering More than One Family (IRS §1.36B-3 (h))

The proposed rule stipulates that if a QHP covers more than one family (i.e. more than one taxpayer and his/her dependents) the applicable taxpayers covered by the plan may each claim a premium tax credit. The rules articulate a specific method for calculating the premium credit amount in this circumstance.

Additional Benefits (IRS §1.36B-3 (j))

The rules also provide a specific method for adjusting monthly premium for the purposes of premium assistance calculation when a QHP offers benefits in addition to the essential benefit package – either voluntarily or as a result of a State mandate. In such circumstances, the proposed rule requires the portion of the premium that is allocable to these additional benefits be excluded from the monthly premiums used to calculate premium assistance amounts.

Families Including Individuals Not Lawfully Present (IRS §1.36B-3 (k))

The proposed rule provides guidance with respect to determining household income in taxpayer families that include individuals who are not lawfully

present, but for whom the taxpayer properly claims a tax deduction. The rules provide a revised household income computation method which excludes the non-lawfully present individual from family size.

RECONCILING THE PREMIUM TAX CREDIT WITH ADVANCE PAYMENTS (IRS §1.36B-4)

The proposed rule outlines the process and general parameters by which advance credit payments are reconciled with allowable tax credits based on a taxpayer's income tax return for the taxable year. The proposed regulations require that the actual premium tax credit is calculated at the end of the taxable year using the taxpayer's household income and family size for the taxable year. If this tax year-end process produces a premium tax credit for the year that exceeds the taxpayer's advance credit payments, he/she is eligible to receive the excess in the form of an income tax refund. Conversely, a taxpayer whose advance payments exceed the allowable tax credit for the taxable year will owe the excess to the IRS as an income tax liability. While these additional taxes are capped for taxpayers with household incomes under 400% FPL, the liability is potentially significant, up to $2,500 for a taxpayer with household income between 300 and 400% FPL. Taxpayers with incomes over 400% of FPL are liable to return the full advance tax credit overpayment.

INFORMATION REPORTING BY EXCHANGES (IRS §1.36 B-5)

The proposed rule outlines reporting requirements of State Exchanges with respect to information reporting related to premium tax credit . Exchanges are required to report to the IRS and taxpayers information including:

- the premium and category of coverage (i.e. self only, family) for the applicable benchmark plan used to calculate advance credit payments;
- the period the coverage was in effect;
- the total premium for the coverage without the reduction of advance credit payments and consumer cost sharing;
- the aggregate amount of advance credit payments or cost sharing reductions;
- the name, address and taxpayer identification number of the primary insurer
- the name and taxpayer identification number (TIN) of each other individual covered under the policy;

- All information provided to the Exchange at the time of enrollment or during the taxable year, including changes in circumstances.

- The proposed rule indicates that the Commissioner of Internal Revenue may promulgate guidance with respect to the timeframes and manner for this reporting.